2211 Sanders Road, Northbrook, IL 60062 Phone (866) 814-5506

Fax Transmittal

Fax: {Auth.OfficeContactFaxNumber}
To: {Auth.ProviderBilling.Name.Legal}

From: CVS

Fax: (855) 330-1720

Re: Prior Authorization for {Auth.Member.MemberNameFirst} {Auth.Member.MemberNameLast}

Electronically (4-5 **minutes** process time)	Phone (10-15 **minutes** process time)	Fax (24-72 **hours** process time)
CVS/Caremark now accepts PA requests on-line 24/7. No fax machines, no phone hold times, faster approval. Most requests will not require a fax or phone call. To request a Prior Authorization online, navigate to https://provider.carefirst.com/providers/home.page and click on the orange tab in the upper right hand corner; or for more details about how to submit and review your prior authorization requests online, view the training video available at www.carefirst.com/learninglibrary > Pharmacy.	Calling us with your PA request during our business hours is another option The process over the phone can take between 10 and 15 minutes. OR online	You may also continue to fax us your PA request Faxes received are processed within 24 to 72 hours. OR online

The information contained in this message may be privileged and confidential and protected from disclosure. If the reader of this message is not the intended recipient, or an employee or agent responsible for delivering this message to the intended recipient, you are hereby notified that any dissemination, distribution, or copying of this communication is strictly prohibited. If you have received this communication in error, please notify us immediately by replying to the message and deleting it from your computer. Thank you, CVS/Caremark.

Member Name: {Auth.Member.MemberNameFirst} {Auth.Member.MemberNameLast} **DOB:** {Auth.Member.MemberBirthDate} **PA Number:** {Auth.AuthID}

Perjeta

Prior Authorization Request

CVS Caremark administers the prescription benefit plan for the patient identified. This patient's benefit plan requires prior authorization for certain medications in order for the drug to be covered. To make an appropriate determination, providing the most accurate diagnosis for the use of the prescribed medication is necessary. **Please respond below and fax this form to CVS Caremark toll-free at 1-855-330-1720**. If you have questions regarding the prior authorization, please contact CVS Caremark at **1-888-877-0518.** For inquiries or questions related to the patient's eligibility, drug copay or medication delivery; please contact the Specialty Customer Care Team: CaremarkConnect® 1-800-237-2767.

The recipient of this fax may make a request to opt-out of receiving telemarketing fax transmissions from CVS Caremark. There are numerous ways you may opt-out: The recipient may call the toll-free number at 877-265-2711, at any time, 24 hours a day/7 days a week. The recipient may also send an opt-out request via email to do_not_call@cvscaremark.com. An opt out request is only valid if it (1) identifies the number to which the request relates, and (2) if the person/entity making the request does not, subsequent to the request, provide express invitation or permission to CVS Caremark to send facsimile advertisements to such person/entity at that particular number. CVS Caremark is required by law to honor an opt-out request within thirty days of receipt.

Patient Name: {Auth.Member.MemberNameFirst} {Auth.Member.MemberNameLast}
Patient's ID: {Auth.Member.MemberID}

Date: {System.DateTime.Today}

Patient's Date of Birth: {Auth.Member.MemberBirthDate}

Physician's Name: {Auth.ProviderBilling.Name.Legal}
Specialty: _____
Physician Office Telephone: {Auth.OfficeContactPhoneNumber}

NPI#: {Auth.ProviderBilling.NPI}
Physician Office Fax: {Auth.OfficeContactFaxNumber}

Referring Provider Info: ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Rendering Provider Info: ❑ **Same as Referring Provider** ❑ **Same as Requesting Provider**
Name: _____ **NPI#:** _____
Fax: _____ **Phone:** _____

Approvals may be subject to dosing limits in accordance with FDA-approved labeling, accepted compendia, and/or evidence-based practice guidelines.

Required Demographic Information:

Patient Weight: _____*kg*

Patient Height: _____*cm*

Please indicate the place of service for the requested drug:

❑ *Ambulatory Surgical* ❑ *Home* ❑ *Off Campus Outpatient Hospital*
❑ *On Campus Outpatient Hospital* ❑ *Office* ❑ *Pharmacy*

Criteria Questions

What is the ICD-10 code? _____

1. What is the patient's diagnosis?
   - ❒ Breast cancer (If checked, go to 2)
   - ❒ Colorectal cancer, including appendiceal adenocarcinoma (If checked, go to 2)
   - ❒ Salivary gland tumors (If checked, go to 2)
   - ❒ Hepatobiliary cancers (including intrahepatic and extrahepatic cholangiocarcinoma and gallbladder cancer) (If checked, go to 2)
   - ❒ Other, please specify. _____ (If checked, go to 2)

Send completed form to: Case Review Unit CVS Caremark Specialty Programs Fax: 1-855-330-1720

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2. Is the request for a continuation of therapy with the requested drug?
   - ❒ Yes (If checked, go to 3)
   - ❒ No (If checked, go to 6)

3. Is there evidence of unacceptable toxicity or disease progression while on the current regimen?
   - ❒ Yes (If checked, go to 4)
   - ❒ No (If checked, go to 4)

4. In what clinical setting is the requested drug being used?
   - ❒ Neoadjuvant (pre-operative) treatment of breast cancer (If checked, go to 5)
   - ❒ Adjuvant treatment of breast cancer (If checked, go to 5)
   - ❒ Treatment of recurrent breast cancer (If checked, *no further questions*)
   - ❒ Treatment of metastatic breast cancer (If checked, *no further questions*)
   - ❒ Treatment of breast cancer with no response to preoperative systemic therapy (If checked, *no further questions*)
   - ❒ Treatment of colorectal cancer (including appendiceal adenocarcinoma and anal adenocarcinoma) (If checked, *no further questions*)
   - ❒ Treatment of salivary gland tumor (If checked, *no further questions*)
   - ❒ Treatment of hepatobiliary cancers (including intrahepatic and extrahepatic cholangiocarcinoma and gallbladder cancer) (If checked, *no further questions*)
   - ❒ Other, please specify. _____ (If checked, *no further questions*)

5. How many months has the patient received therapy with the requested medication?

   _____ months (*no further questions*)

6. What is the patient's diagnosis?
   - ❒ Breast cancer (If checked, go to 7)
   - ❒ Colorectal cancer (including appendiceal adenocarcinoma and anal adenocarcinoma) (If checked, go to 14)
   - ❒ Salivary gland tumor (If checked, go to 20)
   - ❒ Hepatobiliary cancers (including intrahepatic and extrahepatic cholangiocarcinoma and gallbladder cancer) (If checked, go to 23)

7. What is the human epidermal growth factor receptor 2 (HER2) status of the disease? ***ACTION REQUIRED***: Please attach chart note(s) or test results of human epidermal growth factor receptor 2 (HER2) status.
   - ❒ HER2 positive ***ACTION REQUIRED***: Submit supporting documentation (If checked, go to 8)
   - ❒ HER2 negative ***ACTION REQUIRED***: Submit supporting documentation (If checked, go to 8)
   - ❒ Unknown (If checked, go to 8)

8. In what clinical setting is the requested drug being used?
   - ❒ Neoadjuvant (pre-operative) therapy (If checked, go to 9)
   - ❒ Adjuvant therapy (If checked, go to 10)
   - ❒ Treatment of recurrent disease (If checked, go to 13)
   - ❒ Treatment of metastatic disease (If checked, go to 13)
   - ❒ Treatment of breast cancer with no response to preoperative systemic therapy (If checked, go to 13)
   - ❒ Other, please specify. _____ (If checked, *no further questions*)

9. Is the disease locally advanced, inflammatory, or early stage (either greater than 2 cm in diameter or node positive)?
   - ❒ Yes (If checked, go to 11)
   - ❒ 1 month (If checked, go to 11)

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10. Is the disease either node-positive or at high risk for recurrence?
    - ❒ Yes (If checked, go to 11)
    - ❒ 1 month (If checked, go to 11)

11. Will the requested drug be used in combination with trastuzumab and chemotherapy?
    - ❒ Yes (If checked, go to 12)
    - ❒ No (If checked, go to 12)

12. Please indicate how many months of therapy with the requested drug the patient has previously been treated with:

    _____ months or greater (*no further questions*)

13. Will the requested drug be used in combination with trastuzumab?
    - ❒ Yes (If checked, *no further questions*)
    - ❒ No (If checked, *no further questions*)

14. Does the patient have human epidermal growth factor receptor 2 (HER2)-amplified disease? ***ACTION REQUIRED***: If Yes, Please attach chart note(s) or test results of human epidermal growth factor receptor 2 (HER2) status.
    - ❒ Yes ***ACTION REQUIRED***: Submit supporting documentation (If checked, go to 15)
    - ❒ No (If checked, go to 15)
    - ❒ Unknown (If checked, go to 15)

15. Does the patient have RAS and BRAF wild-type disease? ***ACTION REQUIRED***: If Yes, Please attach chart note(s) or test results of RAS and BRAF mutation status.
    - ❒ Yes ***ACTION REQUIRED***: Submit supporting documentation (If checked, go to 16)
    - ❒ No (If checked, go to 16)
    - ❒ Unknown (If checked, go to 16)

16. Has the patient previously been treated with a HER2 inhibitor?
    - ❒ Yes (If checked, go to 17)
    - ❒ No (If checked, go to 17)

17. Will the requested drug be used in combination with trastuzumab?
    - ❒ Yes (If checked, go to 18)
    - ❒ No (If checked, go to 18)

18. Will the requested drug be used as subsequent therapy for progression of advanced or metastatic disease?
    - ❒ Yes (If checked, *no further questions*)
    - ❒ No (If checked, go to 19)

19. Is the patient appropriate for intensive therapy?
    - ❒ Yes (If checked, *no further questions*)
    - ❒ No (If checked, *no further questions*)

20. What is the human epidermal growth factor receptor 2 (HER2) status of the disease? ***ACTION REQUIRED***: Please attach chart note(s) or test results of human epidermal growth factor receptor 2 (HER2) status.
    - ❒ HER2 positive ***ACTION REQUIRED***: Submit supporting documentation (If checked, go to 21)
    - ❒ HER2 negative ***ACTION REQUIRED***: Submit supporting documentation (If checked, go to 21)
    - ❒ Unknown (If checked, go to 21)

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21. Does the patient have recurrent disease?
    - ❒ Yes (If checked, go to 22)
    - ❒ No (If checked, go to 22)

22. Will the requested drug be used in combination with trastuzumab?
    - ❒ Yes (If checked, *no further questions*)
    - ❒ No (If checked, *no further questions*)

23. What is the human epidermal growth factor receptor 2 (HER2) status of the disease? ***ACTION REQUIRED***: Please attach chart note(s) or test results of human epidermal growth factor receptor 2 (HER2) status.
    - ❒ HER2 positive ***ACTION REQUIRED***: Submit supporting documentation (If checked, go to 24)
    - ❒ HER2 negative ***ACTION REQUIRED***: Submit supporting documentation (If checked, go to 24)
    - ❒ Unknown (If checked, go to 24)

24. What is the clinical setting in which the requested drug will be used?
    - ❒ Unresectable disease (If checked, go to 25)
    - ❒ Metastatic disease (If checked, go to 25)
    - ❒ Other, please specify. _____ (If checked, go to 25)

25. What is the place in therapy in which the requested drug will be used?
    - ❒ First-line treatment (If checked, go to 26)
    - ❒ Subsequent treatment (If checked, go to 26)

26. Will the requested drug be used in combination with trastuzumab?
    - ❒ Yes (If checked, *no further questions*)
    - ❒ No (If checked, *no further questions*)

I attest that this information is accurate and true, and that documentation supporting this information is available for review if requested by CVS Caremark or the benefit plan sponsor.

X_____
Prescriber or Authorized Signature **Date (mm/dd/yy)**

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